Rev. 6/00

Brooklyn Developmental Disabilities Service Office

COMPREHENSIVE FUNCTIONAL ASSESSMENT
ANNUAL INDIVIDUAL PROGRAM PLAN MEETING

Client's Name: VALERIE YOUNG *C#:* _____ *Residence:* 314

Date of Program Planning: APRIL 13, 2005

INTERDISCIPLINARY TREATMENT TEAM

[signature]	*Team Leader*
[signature] ce 45-1	*Client Coordinator*
[signature]	*Physician*
[signature]	*Nurse*
[signature]	*Pharmacist*
[signature]	*Dietician*
Teresa Watson	*Day Program*
/	*Rehab. Program*
/	*Outside Prog. Liaison*
[signature]	*Psychologist*
[signature]	*Social Worker*
Karen R Robello DAT	*Direct Care*
	Recreation
/	*Physical Therapist*
/	*Occupational Therapist*
[signature]	*Speech Pathologist*
[signature] Attorney Rep	*Other/Sign Title*
	Client
	Correspondent

Parent/Correspondent was (✓) was not ( ) invited to attend the meeting.
Parent/Correspondent did ( ) did not (✓) attend the meeting.

The Client was (✓) was not ( ) at the meeting.
Client is able ( ) not able (✓) to meaningfully participate in development of the plan.

The ITT reviewed the current level of care does ( ) does not (✓) recommend a change in the residential placement at this time. Recommendation for change: /

The ITT recommended the following program placement: ATP Pros Bldg 5

The ITT recommends integration of the following programs: Psych, Psychiatrist, SW, MD/Diet, Rec

Brooklyn Developmental Disabilities Service Office

ANNUAL CFA TEAM MEETING DISCUSSION

I. Identifying Information

Consumer's Name: Valerie Young **Date of Meeting: 4-13-05**
D.O.B. 8-6-55 **Gender: female**

Diagnosis:

Axis I schizoaffective disorder/intermittent explosive disorder
Axis II profound mental retardation
Axis III constipation, seizure disorder, mild EPS

Unit: 3-1 **Wing: 314**

Legal Guardianship: Mrs. Young, Valerie's mother, is interested in seeking legal guardianship of her daughter and is in the process of filing the papers.

II. Physical Development & Health Status

Any significant medical findings

Valerie is a 49 year old ambulatory (but with left foot drop and high steppage gait), verbal woman who functions within the profound range of mental retardation. She has a history of seizure disorder, which is well controlled with Topamax (see also special meeting minutes 5/6). She sees the neurologist yearly or as needed. Valerie also suffers from constipation (h/o severe impaction) and she receives Metamucil, Colace and a Fleet enema three times per week. Her diet is also high in fiber and extra fluids are encouraged in order to aid the BM. Valerie had a mammogram attempted 3/05 and was uncooperative. Manual breast exams continue to be a part of her yearly physical.

Valerie's psychotropic medications have changed over the year, and she continues to exhibit mild EPS (however improved in comparison to previous years). When Valerie is sedated or unsteady on her feet, the team agrees for a wheelchair to be utilized (and also for longer distance transportation). Overall Valerie has been more alert and psychiatrically stable the past few months. See psychiatric findings for more info on the psychotropic medication regimen.

The team agrees that Valerie should receive a small dose of medicine for sedation/ calming prior to clinic visits upon the physician's discretion. BMRC approved the use of pre-sedation on 11-7-04 and informed consent was given on 12-30-04.

Current Health Status

Valerie's health status is currently stable (primary concern is behavior status and psychotropic medication regimen). Current medications: Topamax 100mg BID,

Remeron 45mg HS, Inderal 80mg TID, Tegretol 400mg/am, 400mg/pm and 400mg/hs, Prevacid 15mg hs, Colace 200mg hs, Metamucil 2tsp QOD/hs; Zyprexa 20mg BID, Klonopin .5mg hs and Fleet enema 3x/wk per rectum.

The team reviewed Valerie's pharmacy evaluation and agree to the following recommendations: monitor BM, suggest bulk laxative-Metamucil on order, monitor drowsiness, EPS and check baseline EKG and fasting blood sugar every 2-3 months. All recommendations being carried out as appropriate. The team agrees that although Valerie exhibits some drowsiness in the morning hours, it is still a marked improvement from past observations where it occurred throughout the day. EPS is mild at this time.

Serious Illnesses/Injuries/Hospitalization during the past year.
On 11-3-04, upon return from program, Valerie was observed with her 2nd and 3rd digits of her left hand swollen and discolored. She was sent out for evaluation to rule out fracture, which was negative. Valerie was diagnosed with a soft tissue contusion and the fingers were wrapped up. The physician stated that she will be re-evaluated as needed. Staff reported that Valerie swings her hands (possibly that's how she sustained the injury?) and the psychologist placed a baseline in for that behavior. That behavior is now being tracked in her plan for disruption. Valerie was also placed on 15 minute checks. No further incidents with hand swinging have been noted.

Allergies
Nevane and Haldol caused EPS, Depakote caused elevated Amylase level

Sleep Habits (include special needs, i.e., bedrails, oxygen, etc.)
Has bouts of insomnia over the year; Medication for sleep and to aid nighttime agitation is on order. The team reviewed the evening and nighttime logs and note that Valerie is up at night fairly often. However, she is calm during these times and not engaging in disruptive behaviors (which is an improvement as well). This could contribute to the am grogginess that has been noted. The physician recommended changing her Zyprexa evening dose to HS in order to further aid nighttime sleep. The team agreed to the recommendation.

Dental findings
On 5-11-04 and 12-22-04 Valerie had tooth extractions done without complication. As per dental exam on 9-28-04: Valerie has non-inflamed soft tissue, restored teeth, missing teeth, decalcification and periodontitis advanced. Valerie is very uncooperative during exams and requires sedation prior to treatment (BMRC/informed consent rec'd). She lacks the cognitive ability to wear dentures. Valerie's oral hygiene is noted to be poor and therefore the team recommends the continuance of the oral hygiene goal to address the need.

Any significant psychiatric findings
Valerie has a diagnosis of schizoaffective disorder/intermittent explosive disorder including severe behavior problems of agitation, aggression, assault, property

liquid/solid form of medication and can drink water from a cup to accompany the medicaiton. The nurse indicates that Valerie is now capable to work on holding med cup/glass steady while pills/water are put in. The team agreed to the assessment. Valerie's response and cooperation can be inconsistent depending upon behavioral status. She continues to be encouraged to participate to the best of her ability.

Team Recommendations:

Age appropriate preventative medical and supportive care, regular psychiatric and neurological follow up, annual optometric and audiological screening and monitoring for potential adverse effects of psychotropic/neuroleptic medications. Wheelchair for mobility as needed and for longer distance transportation.

III. **Nutrition:**

Review of assessment. Include current diet, rationale and any special dietary needs. Include discussion of any significant weight gain/loss.

Valerie has been receiving a chopped hi fiber high calorie diet with prune juice 8oz with breakfast and dinner, 2tb bran with breakfast and extra fluids. March '05 weight is 148 lbs. which reflects overall stable weight maintenance over the year (weight has fluctuated 142-148 pounds during this time). Fluctuations could be due to psychotropic medication changes. A significant weight loss of 12 pounds was exhibited in August, however it was a possible scale error. Even though Valerie is above her IBW of 125-135 lbs., the dietician does not recommend any changes since Valerie can lose weight easily (becomes very hyper). If significant weight gain occurs, the team will re-evaluate. Valerie has an average to good appetite and completes most of her meals. Her self feeding skills vary depending upon behavioral status. Valerie utilizes a built up handle teflon coated spoon and high sided dish with non slip pad to aid dining skills. Walking in the evening time should be encouraged to aid weight loss; however it is difficult to execute during times of uncooperative/unmanageable behavior.

Team Recommendations:

Continue present diet and monitor weight closely. Choking precautions. Encourage exercises as tolerated.

IV. **Sensory/Motor:**

Review of assessment. Include program, recreation, O.T./P.T. (if indicated) audiological, and eye exam.

Valerie is a verbal, ambulatory (with left foot drop and high steppage gait) woman who has full range of motion in upper and lower extremities. She can make brief eye contact and focus on an object. Valerie is fully sighted and her hearing is within normal limits. Valerie had an audiogram on 5-17-04. Speech awareness or localization was present within normal conversational limits and middle ear function within normal limits. Annual audiogram is recommended. . As of optometry screening 2-2-04, early cataracts were noted and referral to retina clinic was recommended. Valerie kept a follow up appointment at CIH eye clinic on 2-28-05. Posterior vitrous detachment of the left eye was noted. Poor cooperation made the exam very limited. She will be referred back again for follow up. Valerie has good gross motor and fair fine motor skills. She can participate in